Abolish Medi-Cal

TO THE EDITOR: As a general practitioner in a less affluent area, I believe physicians have a responsibility to treat those unable to pay, and therefore am enrolled as a Medi-Cal (Medicaid) provider. I do not expect much profit from this arrangement, but recent experiences have left me chagrined at the built-in unworkability of the Medi-Cal system and contemplating my financial losses.

A few examples will help make my point. A sick young woman came to my office and I diagnosed thyrotoxicosis after a thorough workup. I also irrigated her ears on the same occasion, at her request. Claims were submitted to Medi-Cal for a complete physical and for ear irrigation. Medi-Cal paid me a few dollars for the ear irrigation and denied payment for the physical, due to a rule that if a "procedure" is paid for, no other service can be paid for on the same visit. When I wrote back and offered to withdraw the claim for the ear irrigation if they would pay for the physical, they refused. This is a case of getting less for doing more.

On another occasion, trying to plan ahead, I called the Medi-Cal office and inquired whether they would pay for annual physicals. I was informed they would pay and was given the applicable RVS code. When I submitted claims for physicals with the code given, the claims were rejected with the explanation that Medi-Cal does not pay for this service. I believe this is also known as Catch-22.

Another problem involved the drainage of an abscess, for which I billed with the appropriate RVS code. The claim was rejected due to absence of a "modifier" code, with instructions to consult the Medi-Cal manual or call a certain number for information. My office attempted to call the number for an entire day. When, miraculously, someone answered, by the time I got to the phone (about 30 seconds later), they had hung up. The manual is six inches thick and I have no clue where to find the needed data.

I have come to the conclusion that Medi-Cal is not a system for paying for medical care to the poor; it is a system for denying payment for such medical care. I realize that if I continue to treat poor patients, it will be at my own expense.

My recommendation is that this absurd Medi-Cal program be abolished, and the patients rely on charity or county facilities. It is especially infuriating to contemplate the tax dollars spent on salaries for the administrators of this outrageous fraud. The money would be better spent on health-promoting endeavors such as accident prevention and programs to curtail alcohol, tobacco and drug abuse.

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Eicosapentaenoic Acid, Heart Disease and Iron

TO THE EDITOR: Eskimos have a very low incidence of acute myocardial infarction. Dyerberg and Bang[1] have suggested that they may be protected from acute myocardial infarction by their high plasma levels of eicosapentaenoic acid and other omega-3 polyunsaturated fatty acids. These substances are thought to protect Eskimos from the thromboembolic complications of cardiovascular diseases by reducing platelet aggregability.

I wish to suggest an alternative hypothesis on the relationship between high eicosapentaenoic acid intake and the observed low incidence of ischemic heart disease in Eskimos. Reduced platelet aggregability should not only prevent thrombosis in the coronary arteries but should also induce a bleeding tendency. Increased bleeding times have in fact been found in Eskimos and in volunteers on a diet high in eicosapentaenoic acid.[2] A chronic tendency to bleed may cause a decrease in iron stores because of increased loss of blood (and iron), especially from the gut. The observed low incidence of ischemic heart disease in Eskimos may be primarily a result of iron depletion caused by high plasma levels of eicosapentaenoic acid, reduced platelet aggregability and chronic blood loss from the gut and other sites.

This suggestion is a corollary to the hypothesis that iron depletion protects menstruating women from heart disease.[3,4] Iron depletion or deficiency appears to be a common feature of several conditions associated with reduced incidence of ischemic heart disease: poverty in developing nations, vegetarianism, the long-term use of aspirin or cholestyramine[5] and premenopausal status. In the case of menstrual iron loss, reversal of the condition by simple hysterectomy or natural menopause is associated with both iron repletion and an increased incidence of heart disease. A reduction in the amount of menstrual iron loss such as that observed with the use of oral contraceptives may be associated with an increased risk.

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Percent of Fat in Meat, Poultry and Seafood

TO THE EDITOR: The article "Diet and Health" by Gotto and co-workers in the December issue[1] contains several apparent factual errors as well as some distortions or misrepresentations worthy of comment.

First the factual errors: The authors state, "Seafood, including shellfish and finfish, provides less fat per gram of protein than poultry, beef or pork." Though some seafood is indeed quite low in fat, many types, such as anchovies, herring, mackerel, sardines, shad, trout, tuna (in oil) and eel, are very high in fat (greater than 50% of calories). Other fish that are moderately high in fat (30% to 50% of calories from fat) include albacore, carp, salmon and tuna (drained of oil).[2]

Second, cocoa butter is referred to as a source of saturated fat and is then grouped with other saturated fats that are sources of elevated levels of serum cholesterol. In 1970 Grand and co-workers[3] reviewed the literature on the relationship of cocoa butter and chocolate with cholesterol levels and added further experimental evidence showing that stearic acid (the primary saturated fat in cocoa butter) lacks cholesterol-

raising properties. This apparently little known relationship has been overlooked by a number of writers who continue to list cocoa butter (or chocolate) as a saturated fat that raises serum cholesterol levels.

Third, the authors state that removing chicken skin before cooking decreases the fat that penetrates the lean tissue, but add, "This is not true for turkey; therefore, the skin does not need to be removed before cooking." Since cooked turkey skin is 84% fat,[2] by calories, it seems unlikely that this fat would not also penetrate the lean tissue as it does in chicken.

The distortions or misrepresentations (which I have no reason to suspect are intentional) concern the discussion and listing (in Table 2) of the percent of fat in meat, poultry and seafood. Instead of considering fat content of these foods as percent of total calories, the fat content is listed as percent by weight. The latter gives the impression of a distinctly lower quantity of fat (than is actually there)—see Table 1. Reading the percent of fat by weight tends to give readers a false sense of security when consuming any of the items listed.

Though I would emphasize that I agree with the authors' general advice, I do take issue with the statement, "If lipids reach an acceptable level with only a moderate restriction of fat and cholesterol, that is the level at which a person should be maintained, not a more restricted one." First, "acceptable level" is vague and therefore not very helpful. Though the acceptable level is clearly debatable, I think that most now agree that it is well below the 90th percentile figures which the authors describe as "the upper limits of normal." Second, it has become apparent that reducing fat in the diet is likely to reduce several kinds of cancer risk (as well as several other pathologic conditions).[4,5] Therefore, advising maintenance of only moderate fat restriction as long as cholesterol levels are acceptable denies the patient the other potential benefits that a more restricted fat intake can provide.

Finally, as noted by the most recent American Heart Association joint statement of the Nutrition Committee and the Council on Arteriosclerosis (of which Dr Gotto was a member), "There is the possibility that people whose cholesterol levels are at the upper end of the putative desirable range may still be at higher risk for coronary heart disease than those at the lower end; if so, a maximal reduction of levels may be beneficial."[6] They added, "The recommended diet may reduce risk in ways that are not reflected in plasma lipid values; saturated fats and dietary cholesterol possibly have adverse effects on lipoprotein metabolism not revealed in fasting lipid levels."

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TABLE 1.—*Percent of Fat in Meat, Poultry and Seafood (by Weight, as Represented by Gotto, and by Calories, as Calculated by Freedman)*

	Percent Fat (by weight)	Percent Fat (by calories)
Seafood		
Clams, raw	2.5	21
Flounder, raw	0.8	9
Haddock, raw	0.1	10
Salmon, pink (humpback), raw	3.7	28
Snapper, red and gray, raw	0.9	9
Shrimp, raw	0.8	8
Tuna, water packed	0.8	6
Tuna, oil packed	8.2	37
Poultry		
Chicken, light meat, no skin, roasted	4.5	18
Chicken, dark meat, no skin, roasted	9.7	32
Chicken, light and dark meat with skin, roasted	13.6	53
Turkey, light meat, no skin, roasted	3.2	20
Turkey, dark meat, no skin, roasted	7.2	37
Turkey, light and dark meat, with skin, roasted	9.7	39
Beef		
Flank, round (lean only), cooked	6.1	29
Chuck, porterhouse, T-bone (lean only), cooked	10.3	42
Ground beef, regular, cooked	20.3	64
Lamb		
Shoulder (lean only), cooked	9.6	47
Pork		
Ham (lean only), cooked	9.0	39
Spareribs (lean and fat), cooked	35.1	77
Luncheon Meat and Sausage		
Bologna, beef	28.4	74
Italian sausage, cooked, pork	25.7	76
Pepperoni, pork and beef	43.9	83
Salami, dry, pork	33.7	76
Summer sausage, beef and pork	29.9	76

*Percent fat by calories calculated by multiplying grams of fat/100 grams edible portion times 9 (approximate calories/gram) divided by total calories/100 grams edible portion, then multiplying result times 100.

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Dr Gotto and Ms Scott Reply

TO THE EDITOR: In his letter to the editor, Dr Gerald C. Freedman describes "factual errors," "distortions" and "misrepresentations" in our article, "Diet and Health." He has raised several highly technical points and in every instance we believe that he is wrong. We do agree with him concerning the vagueness of the phrase "acceptable lipid level," however.

Dr Freedman raises the issue of how to interpret data on the fat content of food. It can be presented as either percent by weight or percent of calories. In relative terms, comparable results are achieved—that is, in a list showing fat content in descending order, by either method, the same foods appear first, second, third and so forth. Fat content by weight is the accepted format. The US Department of Agriculture often uses this method for classifying foods. It is used by meat and dairy companies for identifying fat content (1% fat milk, 96% fat-free meat). Most diet materials are written to teach the consumer to use percent fat (by weight) with nutrition labeling. Of course, the numbers are lower with percent per weight than with percent of calories. Both systems require education for use.

Seafood is classified by the US Department of Agriculture